

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07876

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST FLORENCE	MIDDLE L.	LAST ALLEN <i>Allen</i>	2a. DATE OF DEATH		MONTH March	DAY 19	YEAR 1979	2b. HOUR 925 P.M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 6, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1409 W. 41st Street				
14. FATHER'S NAME FIRST MIDDLE LAST Harry Schwartz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Minnie Brokovitz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-56-5179		17. INFORMANT ADDRESS Robert M. Allen Rte 1, Box 142B Cherrywalk Rd Hebron, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vertebral Fractures</i> 4/14/79 DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Seven Colling Artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Arteriosclerosis</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>None</i> <i>yes</i> <i>yes</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>3/19/79</i> to <i>3/19/79</i> , that (I) (we) lost saw the deceased alive on <i>3/19/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>John S. Green</i>		DEGREE		22c. DATE SIGNED 3/19/79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Green, M.D.		22e. ADDRESS <i>Green</i>								
23a. BURIAL, CREMATION, REMOVAL (SP. PERM.) Burial		23b. DATE 3-21-1979		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION Baltimore		COUNTY Maryland		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.				25a. DATE REC'D. BY REGISTRAR MAR 22 1979		25b. REGISTRAR'S SIGNATURE <i>Patricia H. Brady</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

72-07870-25



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-07877			
1. DECEASED NAME (TYPE OR PRINT) <i>Clifton J. Anderson</i>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>March 16 1979 1:45 PM</i>			
3. SEX <i>M</i>		4. RACE <i>NEGRO</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 25 29</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>49</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>CAPE MAY, NJ.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.	
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LINE'S COACH</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Physical Ed</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MD.</i> 13c. COUNTY <i>SOMERSET</i> 13d. CITY OR TOWN <i>PRINCESS ANNE</i>				13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS <i>Box 1003 LIME S</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Howard Anderson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Page</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>156-18-4532</i>		17. INFORMANT ADDRESS <i>Myrtle Anderson (Rel. same as above)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Colon Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1539</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>1539</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/26</i> 19 <i>79</i> , to <i>3/16</i> 19 <i>79</i> , that (I) was lost saw the deceased alive on <i>3/15</i> 19 <i>79</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.							
22b. SIGNATURE <i>Joseph Grasso</i> DEGREE <i>MD</i>				22c. DATE SIGNED <i>3/16/79</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph Grasso</i>	
22e. ADDRESS <i>Peninsula General Hospital Salisbury MD</i>				22f. ADDRESS <i>Salisbury MD</i>		22g. ADDRESS <i>Salisbury MD</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>3-20-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Moriah Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>CAPE MAY N.J.</i>	
24. FUNERAL DIRECTOR NAME <i>Valley Memorial Chapel, Rt. 2, Salisbury, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 27 1979</i>		25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>	

10-07817

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION



Memorandum

Salisbury, Tennessee General Hospital

General Hospital

General Hospital

General Hospital



10-07817

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07878

1. FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) William Henry BAINE		2a. DATE OF DEATH MONTH DAY YEAR MARCH 8 1979		2b. HOUR 10 ⁴⁵ A.M.
3 SEX M	4 RACE Negro	5 DATE OF BIRTH MONTH DAY YEAR 1 25 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.
10 CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Labour	12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS RT #1 Box 93A
14 FATHER'S NAME FIRST MIDDLE LAST William Douglas		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dasha Baine		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. 240-42 4916	17 INFORMANT ADDRESS Gloria Ward (Add. same as above)		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Sepsis 2030 DUE TO, OR AS A CONSEQUENCE OF (b) Multiple myeloma DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) A. S.H.D. Cardiomegaly, Mitral regurgitation, Hypercalcemia				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2/8/79, 19, to 3/8/79, 19, that (I) (we) lost saw the deceased alive on 2/8/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.				
22b. SIGNATURE B. Agarwal MD		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAL K. AGARWAL		22e. ADDRESS 237 FLORIDIA AVE SALISBURY MD 21801		
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 3-13-79	23c. NAME OF CEMETERY OR CREMATORY Mt Hope Baptist	23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.	
24. FUNERAL DIRECTOR Jolley Mem. Chapel Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR MAR 16 1979		
		25b. REGISTRAR'S SIGNATURE Turkey McCreedy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, except in cases of sudden death, in which case it may be executed at any time.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19-07878

Enclosure

Peninsula General Hospital

Salisbury

MAR 1 1978

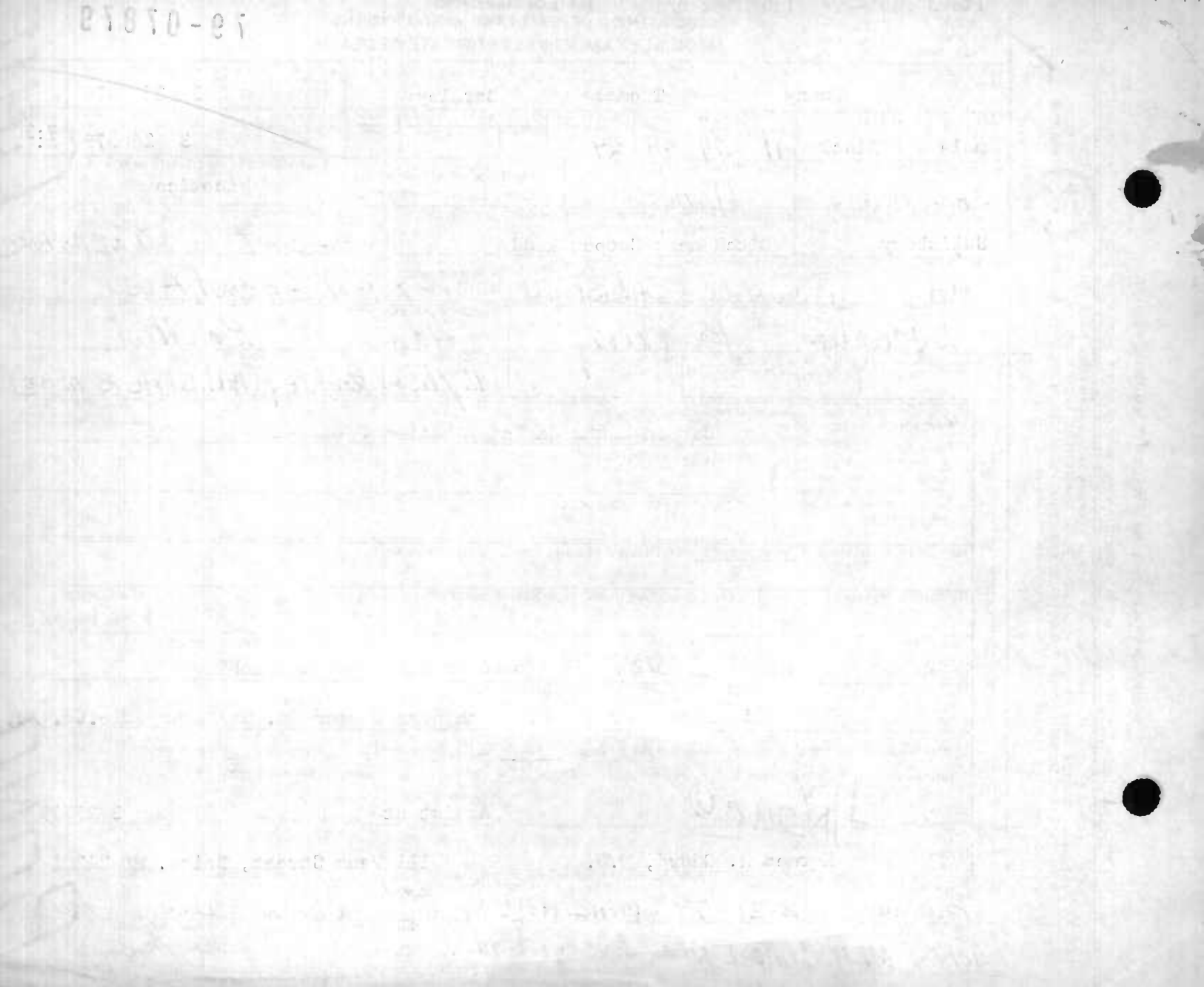
Items #35a-22a Film G532 6/18/79 STATE OF MARYLAND
FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-07879
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			ESTIMATED MONTH DAY YEAR			2b. HOUR		
Lanny Thomas Barkley						3 26 1979						M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
male	Black	11 24 49 29 YRS.				3 26 1979						7:30 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Salisbury			USA						Wicomico					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Ditch near Cooper Road			AGENT			INSURANCE					
13a. STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Md.			Wicomico			Salisbury			F11 GANNET AVE.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Lycurties			Barkley			Ida			Barkley			Phyllis M. Barkley (Add. SAME AS ABOVE)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication 9821 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
			3/26/ 1979			found in burnt out automobile								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
			ditch near Cooper Rd.			Ditch near Cooper Rd. Salisbury Wic.Co. Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED								
Hormez R. Guard			Assistant			3/27/79								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS											
Hormez R. Guard, M.D.			111 Penn Street, Balto. MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			3-31-79			Spring H.L. Memory			Hebron Wico. Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Tolley MEM. CHAPEL			Rt #2 Jersey Rd. Salis.			APR 6 1979			[Signature]					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN FOLDER WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-07880

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
ALBERT		BELL		MARCH 24 1979 11:55 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)		
MALE	CAUC	MONTH DAY YEAR	62 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
USA	USA		Wicomico MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital		business man		Real
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS	
Maryland	Wicomico	Salisbury	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rt 10 Cedar Horse Village	
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
George Emory Bell	Annie E. Brumbley				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
no	214-10-5533	Betty Robbins (Niece)			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac Arrest					MUR
410- DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular Collapse					HRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarction					DEVS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (s) (this hospital) attended the deceased from 3/22 19 79 to 3/24 19 79, that (we) lost saw the deceased alive on 3/24 19 79 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (Type name of physician or medical examiner who did not view the body after death.)					
22b. SIGNATURE		DEGREE	22c DATE SIGNED		
Donald M. Wood		MD	3/24/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
DONALD M. WOOD		215 OHIO AVE SALISBURY MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE	
Removal	3/25/79				
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Anatomy Board		Balto., Md.		MAR 29 1979 History McCreedy	

BP

08870-21

10-10-60

General Hospital

Salisbury

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-07881

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
GRACE EVELYN BOGGS		FEB 25, 1979		11 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	WHITE	SEPT 30 1907	71	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
TENNESSEE	U.S.A.		WORCESTER MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF YEAR)		12b. KIND OF BUSINESS OR INDUSTRY
WHALEYVILLE	AT HOME		REGISTERED NURSE		NURSING
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WORCESTER	WHALEYVILLE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	R.D.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
WALTER PULLEY		MOLLIE (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
		212-32-1158	KENNY BOGGS WHALEYVILLE MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY					
7209 } DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
COMPRESSION OF MEDULLA SPINALIS					
DUE TO, OR AS A CONSEQUENCE OF					
CERVICAL SPONDILITIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
DIABETES MELLITUS, HYPERTENSION, QUADRIPLEGIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from MAY 8, 1973 to FEB. 25, 1979, that (I) (we) lost the deceased alive on FEB. 23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Alfredo B. Fernandez M.D.		MD		2-26-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ALFREDO B. FERNANDEZ		OCEAN CITY BLVD. BERLIN, MD. 21811			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
BURIAL		2/28/79	DALE		WHALEYVILLE WORCESTER MD
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Peter Whaley		Sellyville, Pa.		APR 11 1979	
				25b. REGISTRAR'S SIGNATURE	
				P. B. McCreedy	

18810-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07882

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Lawrence W. Bratten</u>			2a. DATE OF DEATH MONTH <u>3</u> DAY <u>12</u> YEAR <u>79</u>			2b. HOUR <u>11:55</u> ^A M	
3. SEX <u>M</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH MONTH <u>July</u> DAY <u>17</u> YEAR <u>1874</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD	
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>River Walk Manor Nursing Ho</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
13a. STATE <u>Md.</u>		13b. COUNTY <u>Worcester</u>		13c. CITY OR TOWN <u>Focomoke</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <u>Charles</u> MIDDLE <u>Bratten</u> LAST <u>Bratten</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Unknown</u> MIDDLE <u>Unknown</u> LAST <u>Unknown</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>216-40-3965</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>		18. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>436- Cerebral arteriosclerosis</u>		19. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u>		20. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Saulity, Diabetes mellitus</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Saulity, Diabetes mellitus</u>							
9a. DATE OF OPERATION <u>March 12</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Diabetes mellitus</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Home</u>		21f. LOCATION STREET <u>Pinch Bluff Road</u> CITY OR TOWN <u>Salisbury</u> COUNTY <u>Wicomico</u> STATE <u>Md.</u>			
22a. I certify that <u>Thomas C. Hill Jr.</u> (this hospital) attended the deceased from <u>August 10</u> , 19 <u>78</u> , to <u>March 12</u> , 19 <u>79</u> , that <u>we</u> (we) last saw the deceased alive on <u>March 12</u> , 19 <u>79</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Thomas C. Hill Jr.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/12/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS C. Hill Jr.</u>		22e. ADDRESS <u>Pinch Bluff Road Salisbury Md.</u>					
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>3-17-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Holiness Cem.</u>		23d. LOCATION CITY OR TOWN <u>Snow Hill</u> COUNTY <u>Wicomico</u> STATE <u>Md.</u>	
24. FUNERAL DIRECTOR <u>James S. Sargent</u>		ADDRESS <u>New Church, Va.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 22 1979</u>		25b. REGISTRAR'S SIGNATURE <u>James S. Sargent</u>	

10-01885

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07883

REG. NO.

FOR
1 - STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUSSELL W. Breneman			2a. DATE OF DEATH MONTH DAY YEAR March 16 79		2b. HOUR 2:55 M				
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 13, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. MONTHS DAYS HRS. MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Watchman		12b. KIND OF BUSINESS OR Suburban Dev. Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY =		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST John Breneman			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Greenland		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) Yes W.W.I.			16b. SOCIAL SECURITY NO. 215-05-6382	
17 INFORMANT ADDRESS Bertha Hall (dgtr) 6330 Lee Street Hollywood, Fla. 33024									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unstable heart failure</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>79</u> , to <u>3/16</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>3/15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M Ben Horner MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/16/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B Horner				22e. ADDRESS Kay Ave Salisbury Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/20/79		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR MAR 19 1979		25b. REGISTRAR'S SIGNATURE R. J. McElroy			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88870-91

10/10/79

10/10/79

10/10/79

10/10/79

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07884

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KARI LYNN BUCHANAN			2a. DATE OF DEATH MONTH MARCH DAY 6 YEAR 1979			2b. HOUR 1:48 M			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 6 YEAR 79		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 1 25		IF UNDER 1 YEAR HOURS MIN 1 25	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY WICOMICO 13c. CITY OR TOWN W. CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13th ST.				
14. FATHER'S NAME FIRST LARRY MIDDLE T. LAST BUCHANAN			15. MOTHER'S MAIDEN NAME FIRST JOAN MIDDLE JESTER LAST BUCHANAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS LARRY BUCHANAN OCEAN CITY MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Total Pulmonary atelectasis 7566 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Diaphragmatic Hernia & abdominal (c) Viscera filling & hemithorax & displacement of heart & lungs to Right PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) & Compression of Lungs preventing oxygenation								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 85 min	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/6/79 19____, to 3/6/79 19____, that (I) (we) last saw the deceased alive on 3/6/79 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Chester C. Collins MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chester C. Collins				22e. ADDRESS Medical Center Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-9-79		23c. NAME OF CEMETERY OR CREMATORY SUNSET M.P.		23d. LOCATION CITY OR TOWN BERLIN COUNTY WICOMICO STATE MD			
24. FUNERAL DIRECTOR NAME ULLRICH FUNERAL HOME ADDRESS BERLIN, MD.				25a. DATE REC'D. BY REGISTRAR MAR 23 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-07684



Section

Colombian General Hospital

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-07885

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Martin James Calloway			2a. DATE OF DEATH MONTH DAY YEAR March 21, 1979		2b. HOUR 5:35 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 25 1910	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber	12b. KIND OF BUSINESS OR INDUSTRY Barbering	
13a. STATE Maryland			13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Calloway			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Hall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221-05-5486	17. INFORMANT ADDRESS Mrs. Florence W. Calloway 1208 Edgemont Ave. Salisbury, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarct 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease yrs DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Jan 19 64, to Mar 21 19 79, that (1) (we) lost saw the deceased alive on Mar 21 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If/ we (did) did not) view the body after death.					
22b. SIGNATURE John T. Bulkeley M.D.		DEGREE M.D.		22c. DATE SIGNED 3-23-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN T. BULKELEY		22e. ADDRESS PINE BLUFF ROAD SALISBURY MD 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-24-79	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Maryland	
24. FUNERAL DIRECTOR NAME Holloway Funeral Home P.A.		ADDRESS Snow Hill Rd. Salisbury		25a. DATE REC'D. BY REGISTRAR MAR 27 1979	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

The medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

2880-27

Calicut General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 27 is marked or item 38 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the coroner, it must be returned to the coroner's office. The coroner's office should be deducted for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be placed with 2255-2556 by deposit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, then only injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-07886	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		3. SEX			
DANIEL PERRY Church			MARCH 24 1979			9 30 AM		MALE			
4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			
Neg			6/10/1896			83 YRS		md			
8. CITIZEN OR WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
USA			Wicomico			Salisbury		Peninsula General Hospital			
12. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			13. KIND OF BUSINESS OR INDUSTRY			14. FATHER'S NAME (TYPE OR PRINT)			15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		
J. Well Lumber						DANIEL Church			Mary Jones		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)			17. SOCIAL SECURITY NO.			18. INFORMANT			19. ADDRESS		
No			218-05-7275			Arletta Atkins			20. ADDRESS		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____			21. DUE TO, OR AS A CONSEQUENCE OF (b) _____			22. DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4392			Coronary Thrombosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
23a. DATE OF OPERATION			23b. CONDITION FOR WHICH OPERATION WAS PERFORMED			24a. AUTOPSY?		24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
25a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
26a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			26c. LOCATION STREET CITY OR TOWN COUNTY STATE					
27. I certify that (I) (this hospital) attended the deceased from 3-23-1979, to 3-24-1979, that (I) (we) last saw the deceased alive on 3-24-79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
28a. SIGNATURE			28b. DEGREE			28c. ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN			28d. DATE SIGNED		
James H. Clifford M.D.			M.D.			Director			3/24/79		
29a. PHYSICIAN'S NAME (TYPE OR PRINT)			29b. ADDRESS			30a. NAME OF CEMETERY OR CREMATORY			30b. LOCATION CITY OR TOWN		
James H. Clifford M.D.			MEDICAL CENTER Salisbury, Me			Greenwood Memorial			Salisbury, Me		
31a. FUNERAL DIRECTOR NAME			31b. ADDRESS			31c. DATE REC'D. BY REGISTRAR			31d. REGISTRAR'S SIGNATURE		
West-Fork Funeral Home			Salisbury, Md.			MAR 28 1979			[Signature]		

19-07886

Wisconsin

Calderbury
Fennema General Hospital

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07887

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Harold D. Cutright					MARCH 25, 1979				11:50 AM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	White	April 15, 1903		75	MONTHS		DAYS		HOURS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia	USA			Wicomico MD					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury	Peninsula General Hospital			Machinist		Auto			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS		
Maryland Worcester		Snow Hill				106A N. Church St.			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Delos Cutright		Lucy Haskins							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		218 245275		Catherine H. Cutright, Snow Hill Md.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Cardiovascular Disease</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3-1-</u> 19 <u>79</u> , to <u>3-25-</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>3-25</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED	
James H. Clifford		MD						3-25-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
JAMES H. CLIFFORD		MEDICAL CENTRE			SALISBURY MD				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		3-28-79		Union		Stockton, Maryland			
24 FUNERAL DIRECTOR NAME		ADDRESS			25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Norman F. Hennis		Snow Hill, Md.			MAR 30 1979		Hickory McBrady		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

19-07887

Michigan

Michigan General Hospital

Salisbury

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07888

1. DECEASED NAME (TYPE OR PRINT) CALEB DAVIS			2a. DATE OF DEATH MONTH DAY YEAR March 30, 1979			2b. HOUR 9:30 AM			
3 SEX Male		4 RACE NEGRO		5 DATE OF BIRTH MONTH DAY YEAR 1 3 49		6 AGE (IN YEARS LAST BIRTHDAY) 80		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY FARMER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. COUNTY Worcester 13d. CITY OR TOWN BERLIN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt # 2				
14 FATHER'S NAME FIRST MIDDLE LAST Wesley DAVIS			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Spence						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO 214-12-3157		17 INFORMANT NAME ADDRESS Nette Purnell, Rt # 3 Box 321				
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF c) cellular								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 79 , to 3-30 , 19 79 , that (I) (we) last saw the deceased alive on 3-30 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William A. E. [Signature]						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-30-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPRINT) Burial			23b. DATE 4-3-79		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN WORE Md.		
24. FUNERAL DIRECTOR NAME ADDRESS JOSEY MEM. CHAPEL Rt 2, Jersey Rd, SALIS. Md.						25a. DATE REC'D. BY REGISTRAR APR 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

19-07888

California Peninsula General Hospital

19-07888

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VRA 15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

79-07889

1. DECEASED-NAME (Type or print) First Middle Last ROSCOE Anstine DENNIS			2a. DATE OF DEATH Month Day Year 3 12 1979			2b. HOUR a 2:40 ^a			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 15, 1915		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Powellville, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired owner		12b. KIND OF BUSINESS OR INDUSTRY Oil Company			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1121 Taney Ave.	
14. FATHER'S NAME First Middle Last Robert A. Dennis			15. MOTHER'S MAIDEN NAME First Middle Last Edna Parker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 217-01-6798		17. INFORMANT Address Mrs. Kathrynne Dennis (wife) same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinoma of lung with</i> 1629 DUE TO, OR AS A CONSEQUENCE OF <i>metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 79			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 2/16, 1979, to 3/12, 1979, that (I) (we) last saw the deceased alive on 3/11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Earl M. Beardsley MD</i>		22c. DATE SIGNED 3/12/79			22d. ADDRESS 21801		22e. ADDRESS U.S. 50 AT CIVIC AVENUE, SALISBURY, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/14/79		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland		23e. RECORD BY REGISTRAR MAR 15 1979	
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland		24b. ADDRESS			25a. RECORD BY REGISTRAR DATE		25b. SIGNATURE <i>Kathrynne Dennis</i>		

03050-01

1

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-07890

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) CYRUS LEWIS Dirickson			2a DATE OF DEATH MONTH DAY YEAR March 31, 1979			2b HOUR 6:02 PM				
3 SEX M		4 RACE CAU.		5 DATE OF BIRTH MONTH DAY YEAR ✓		6 AGE (IN YEARS, LAST BIRTHDAY) ✓		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Wic			13c CITY OR TOWN Salisbury			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Cyrus B. Dirickson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HESTER LEWIS							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) NO			17 INFORMANT ADDRESS MRS. C. L. Dirickson Salisbury MD				
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm 4413 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic disease of the aorta DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 Hr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no										
19a DATE OF OPERATION 3-30-79			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abdominal aneurysm			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 3-30 , 19 79 to 3-31 , 19 79 , that (I) (we) last saw the deceased alive on 3-31 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Neuvins W. Todd			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3-31-79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Neuvins W. Todd			22e ADDRESS Berlin Md							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 4/3/79		23c NAME OF CEMETERY OR CREMATORY ST. PAUL'S CHURCH		23d LOCATION CITY OR TOWN COUNTY STATE BERLIN MD MD			
24 FUNERAL DIRECTOR NAME Anna A. Brubaker			ADDRESS Berlin Md			25 DATE RECEIVED BY REGISTRAR APR 9 1979		25 REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be sealed at once.

BP

00870-07

Michigan

Salisbury Penitentiary General Hospital

00870-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-07891
REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) Edgar O. Dix, Jr.		2b. DATE OF DEATH MONTH DAY YEAR March 1 1979		2c. HOUR 22 ³⁰ M	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Aug 24 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber Ret.		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar O. Dix, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella E. Minniss		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213 10 4874	
17. INFORMANT ADDRESS Gordon L. Dix Reisterstown, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery disease</u> 30 years DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal failure</u> 3 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years		30 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 9-21-78 to 3-1-79, that (1) (we) last saw the deceased alive on 3-1-79 and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.							
22b. SIGNATURE Roger Merrill		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-1-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Merrill		22e. ADDRESS 307 Kay Ave, Salisbury, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3-5-79		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto Maryland	
24. FUNERAL DIRECTOR NAME Frank H. Newell, Inc.		ADDRESS Pikesville, Md.		25a. DATE REC'D. BY REGISTRAR MAR 6 1979		25b. REGISTRAR'S SIGNATURE L. H. H. H.	

100-01001

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MEMORANDUM

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

FILE NO. [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

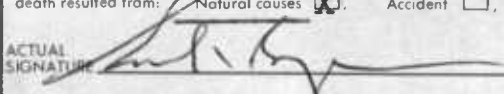
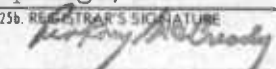
23. [Illegible]

24. [Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-07892			
1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHERINE ANN DOUGHERTY										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3-27-79		2b. HOUR 8 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 24 1898		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 3-27-79 10 A.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Mardela			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 74			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Mardela		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 74					
14. FATHER'S NAME FIRST MIDDLE LAST Warren Hyde						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Ellis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-14-6179		17. INFORMANT ADDRESS Katherine Shaffer, Mardela Springs, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 3-27-79					
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/30/1979		23c. NAME OF CEMETERY OR CREMATORY Mardela Memorial Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Mardela Springs, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Hill-Baker-Bounds, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR APR 2 1979		25b. REGISTRAR'S SIGNATURE 					

10-08802

X 10-27-79

RECEIVED AND DOCUMENTED

Female - White M. 21 1998 10 - 10-27-79 10 A

Wisconsin

Virginia

Box 10

Box 10

Box 10

Box 10

Box 10

10-11-1999

ABOUT

X

X X

10-27-79

10-27-79

103 Graham Ave., Salisbury, Md.

103 Graham Ave., Salisbury, Md.

10-27-79

103 Graham Ave., Salisbury, Md.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07893

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edwin F. FRANKLIN East			2a. DATE OF DEATH MONTH DAY YEAR March 01, 1979		2b. HOUR 10:30A _M
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 9 10 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U-S-A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER	12b. KIND OF BUSINESS OR INDUSTRY Crew Shop.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS S. Division St	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-32-6023		17. INFORMANT ADDRESS Kathryn Kolb, Camden Ave Salisbury Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS SEVERAL YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 02/28/79, 19____, to 03/01____, 1979, that (I) (we) last saw the deceased alive on March 01, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. Wilberg MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-1-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Wilberg, M.D.		22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801			
23a. MANNER OF DEATH (BURIAL, CREMATION, REMOVAL) BURIAL		23b. DATE 3/3/1979	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD.
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds		ADDRESS Salisbury, MD		25a. DATE REC'D. BY REGISTRAR MAR 5 1979	
				25b. REGISTRAR'S SIGNATURE Kathryn Kolb	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19-07893

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO :

FROM :

SUBJECT :

DATE :

RE :

BY :

DATE :

RE :

RE :

RE :

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RE :

RE :

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-07894 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HATTIE ENGLES						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> 3-13-79		2b. HOUR 9 A		M	
3. SEX Female		4. RACE AA		5. DATE OF BIRTH MONTH DAY YEAR 2 27 15		6. AGE (IN YEARS) MONTHS DAYS HRS. MIN. 64		IF UNDER 1 YR.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 413 Cypress St.			
14. FATHER'S NAME (FIRST) MIDDLE LAST ISAAC H JONES				15. MOTHER'S MAIDEN NAME (FIRST) MIDDLE LAST MINNIE BROOKS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-142645		17. INFORMANT LEWIS DASHIELL		ADDRESS 413 CYPRESS ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcino Sarcoma (Pelvic) with Metastasis 1953 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 3-13-79			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE 3-17-79		23c. NAME OF CEMETERY OR CREMATORY Greenwood Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD			
24. FUNERAL DIRECTOR NAME ADDRESS				25. DATE REC'D. BY REGISTRAR MAR 19 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					
West-Fooks Funeral Home, Salisbury, Md.											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

9850-09

• **Control:**

1

3

3-13-52

U.S. Navy, 17th

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
79-07895											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) PAUL				2a. DATE OF DEATH MONTH DAY YEAR March 27, 1979				2b. HOUR 509 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 15, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 74 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Poultry Dealer			12b. KIND OF BUSINESS OR INDUSTRY Farm		
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 511 Georgia Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Adolph Feig				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Paula Weiser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 159-09-8113		17. INFORMANT Mrs. Dorothy Feig (wife) same as 13				ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unilateral Aneurysm</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Previous Myocardial Infarction</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Previous Myocardial Infarction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>6-1-77</u> to <u>3-27-79</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12-21-78</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>James H. Clifford</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES H. CLIFFORD</u>				22e. ADDRESS <u>MEDICAL CENTER SALISBURY, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/30/79		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Park, Cornwell Heights				23d. LOCATION CITY OR TOWN COUNTY STATE Pa.			
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a. DATE OF DEATH BY REGISTRATION APR 2 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

10-05802

Victorio

Peninsula General Hospital

Salisbury

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-07896	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE & PRINT) FIRST MIDDLE LAST <i>Caroline L Fooks</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>MARCH 26 1979</i>					2b. HOUR <i>2 45</i> M	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 5-1894</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.					
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>md</i>					13c. CITY OR TOWN <i>Pr. Anne</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>David R. Logan</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ada Cattman</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>212-40-9175-0</i>		17. INFORMANT ADDRESS <i>Rosanna Benson, R. 12 Westover</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of breast with metastases</i> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6/26 19 79</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/26</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard E. Hughes</i>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/27/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard E. Hughes, M.D.</i>				22e. ADDRESS <i>7 Medical Center, Salisbury, Md.</i>							
23a. BURIAL CREMATION, REMOVAL				23b. DATE <i>3/31/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>John Wesley</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Pr. Anne, Somerset, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Addie James</i>				ADDRESS <i>407 Somerset Ave. Anne</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 4 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia McBratney</i>	

MEDICAL CERTIFICATION

88

10-07886

10-07886

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10-07886

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07897

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Sadie E. GALE			2a. DATE OF DEATH MONTH 3 DAY 1 YEAR 79			2b. HOUR 705 P.M.	
3. SEX F	4. RACE BLACK	5. DATE OF BIRTH MONTH 3 DAY 10 YEAR 1893		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Lwicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lwicomico Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Md.		13b. COUNTY Som.	13c. CITY OR TOWN Rehoboth	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rural	
14. FATHER'S NAME FIRST Washington MIDDLE W. LAST GALE		15. MOTHER'S MAIDEN NAME FIRST Harriet MIDDLE Schofield LAST GALE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Intestinal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Dysenteria							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/24/79 , 19 79 , to 3/1/79 , 19 79 , that (I) (we) lost saw the deceased alive on 2/24/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. E. Ward		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/5/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/8/79		23c. NAME OF CEMETERY OR CREMATORY Ebenezer		23d. LOCATION CITY OR TOWN COUNTY STATE Marynesco Som. Md	
24. FUNERAL DIRECTOR NAME Anthony E. Ward ADDRESS Chesapeake, Md.		25a. DATE REC'D. BY REGISTRAR MAR 9 1979		25b. REGISTRAR'S SIGNATURE Richard M. Brady			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-07898	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John H. Gilliss				2a DATE OF DEATH MONTH DAY YEAR March 19, 1979			2b HOUR 2:25 A.M.		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 5-20-17		6 AGE (IN YEARS LAST BIRTHDAY) 61		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b COUNTY Worcester		13c CITY OR TOWN Berlin		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14 STREET ADDRESS St. Martins, Berlin, MD.			
14 FATHER'S NAME FIRST MIDDLE LAST Judge John H. Gilliss				15 MOTHER'S MAIDEN NAME FIRST LAST Ruth Maddox Gilliss							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO 221-10-2859		17 INFORMANT ADDRESS Robbins Gilliss, Berlin, Md. 21011					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 410- Ventricular Fibrillation										7d	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial ischemia											
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease										5y-	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/11/79 to 3/18/79, that (I) (we) lost saw the deceased alive on 3/18/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE				22c. DATE SIGNED 3/20			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. Rafferty				22e ADDRESS Crooked Oak Lane							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 3-21-79		23c NAME OF CEMETERY OR CREMATORY Buckingham Cemetary		23d LOCATION CITY OR TOWN COUNTY STATE Berlin, MD. Worcester			
24 FUNERAL DIRECTOR NAME 108 Williams St. Berlin, Md. 21011						25a. DATE REC'D. BY REGISTRAR MAR 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

9-07888

Wichita

General Hospital

Salisbury

Wichita

Salisbury

Wichita

Salisbury

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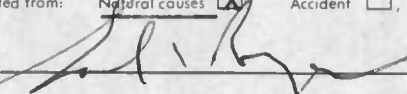

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-07899		
1- STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADIE C. GLASGOW										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3-16-79		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 27 1888		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 90		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2b. HOUR 1A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD			
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Wicomico		13c. CITY OR TOWN Mardela		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Sharptown Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BOSTON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRANDA REDDEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 212-09-7722		17. INFORMANT ADDRESS SHELDON GLASGOW MARDELA, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE 						TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 3-16-79		
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.						ADDRESS 409 Camden Ave., Salisbury, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3-18-79		23c. NAME OF CEMETERY OR CREMATORY MARDELA MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE MARDELA WIC. MD.				
24. FUNERAL DIRECTOR NAME ADDRESS Ullrich Funeral Home, Sharptown, Md.						25a. DATE REC'D. BY REGISTRAR MAR 23 1979		25b. REGISTRAR'S SIGNATURE 				

00000-00

MEMORANDUM FOR THE RECORD

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07900

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN	
FIRST MIDDLE LAST		3 12 79		12 43 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH	
MALE		CAUC		MONTH DAY YEAR	
2		11 19 19		60	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Accomac		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Salisbury		Peninsula General Hospital		Trucker	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY	
Transportation		VA		Accomack	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Atlantic		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Hezekiah		Emma Russell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		374-30-8449		Mrs Catherine Fox - Atlantic, VA 23303	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		MIN'S	
410 - Profound Cardiovascular Collapse		(b) Acute Myocardial Infarction		HRS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c) Atherosclerotic Cardiovascular Disease		YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 3/12, 19 79, to 3/12, 19 79, that (b) (we) lost saw the deceased alive on 3/12, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Amalia M. Brown		MD		3/12/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3-15-1979		Taylor's Memorial	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Temperanceville		Accomack		VA	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE RECD BY REGISTRAR	
Duff		Temperanceville, VA		MAR 19 1979	
				25b. REGISTRAR'S SIGNATURE	
				Duff	

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Peninsula General Hospital

San Francisco

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07901

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Medford			2a. DATE OF DEATH MONTH March DAY 1 YEAR 1979			2b. HOUR 1:10 A M			
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH Nov. DAY 5 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. MONTHS 3 DAYS 26		7. IF UNDER 1 YEAR MONTHS 3 DAYS 26	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Cavanaugh		12b. KIND OF BUSINESS OR INDUSTRY Ford	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 503 Lincoln Ave.	
14. FATHER'S NAME FIRST Charles MIDDLE Haddock LAST Haddock					15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Tingle LAST Tingle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-10-7762		17. INFORMANT ADDRESS Ruth Nancy Haddock Salis., Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b): Atrial fibrillation									
19a. DATE OF OPERATION 2-21-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 2-21-79				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 307 Kay Ave., Salisbury, Md.		CITY OR TOWN Salisbury, Md.		COUNTY Wicomico	
22a. I certify that (1) (this hospital) attended the deceased from 2-21-79 to 3-1-79 , that (2) (we) lost saw the deceased alive 2-28-79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Roger C. Merrill				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-1-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger C. Merrill				22e. ADDRESS 307 Kay Ave., Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-3-1979		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem.		23d. LOCATION CITY OR TOWN Delmar		COUNTY Sussex	
24. FUNERAL DIRECTOR NAME William M. Smith				ADDRESS Delmar, Del. 19940		25a. DATE REC'D. BY REGISTRAR MAR 5 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, such as should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

10270-2

10270-2

10270-2

10270-2

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07902

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZA. DENNIS. Hargis			2a. DATE OF DEATH MONTH DAY YEAR MARCH 29, 1979			2b. HOUR 8:20 PM				
3 SEX FEMALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR 3. 27. 1886		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS MONTHS DAYS HOURS MIN		7 INDEX YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE M.D. 13b. COUNTY SOMERSET 13c. CITY OR TOWN PR. ANNE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RF1. PLINEPOLE, PR. ANNE			
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL DENNIS.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA HANDY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) 0			16b. SOCIAL SECURITY NO 219.02.2613		17. INFORMANT ADDRESS HERBERT S. MORRIS, Rt 2, Box 239					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. chondritum 558- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) enterocolitis DUE TO, OR AS A CONSEQUENCE OF (c) days								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: generalized arteriosclerosis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-28 , 19 79 , to 3-29 , 19 79 . I saw the deceased alive on 3-29 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John G. Bulkeley			DEGREE MD			MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-29-79		
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			22c. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 4/7/1979			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION CITY OR TOWN COUNTY STATE Pr. Anne, Somerset, Md		
24. FUNERAL DIRECTOR Addie James, 407 Somerset Ave.			ADDRESS Pr Anne			25a. DATE REC'D. BY REGISTRAR APR 5 1979		25b. REGISTRAR'S SIGNATURE L. J. McCurdy		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If a body be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

50850-25

20030 - 6513

HEMPLE BLOCK 3, E. 27

8211 011

2000-09-22 00:02:00

THE UNIVERSITY OF CHICAGO



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07903

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CORA AMANDA HARRINGTON			2a. DATE OF DEATH MONTH DAY YEAR March 31, 1979		2b. HOUR AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 4, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 80	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MINS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Zion Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House work		12b. KIND OF BUSINESS OR INDUSTRY none
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Wicomico Salisbury					
14. FATHER'S NAME FIRST MIDDLE LAST Zora Virgil Savage		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Frances Mills			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Maebelle Dunn (daughter) same as 13	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Essential Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 76 to Present (date) 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. David J. Gilmore		DEGREE		22c. DATE SIGNED 4/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. David J. Gilmore		22e. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/3/79		23c. NAME OF CEMETERY OR CREMATORY Eivalve Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Bivalve, Wicomico, Maryland		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE P. K. McCready	
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland		25. DATE REC'D. BY REGISTRAR APR 4 1979			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


10-01803



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 1 AND 2 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-07904	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) CLARA BELL HARRISON										2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3-5-79 4:05A	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 27 1892	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3-5-79 19	7d. HOUR " M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Regina, Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 314 Cherry Way				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ----			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Virginia		13b. CITY Northampton		13c. CITY Cape Charles		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 529 Madison Ave. view			
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Talley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Pittman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT Mr. John William Harrison (husband)		ADDRESS same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 3-5-79			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/7/79		23c. NAME OF CEMETERY OR CREMATORY Onancock Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Onancock Accomack Virginia			
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 7 1979				25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) RENA MARIE Hitchcock					2a. DATE OF DEATH MONTH DAY YEAR March 25 1979			2b. HOUR 7:21 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 6, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Food Freezing	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 200 Cedar-Way	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Corr					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-16-3553		17. INFORMANT ADDRESS 608 Dover Street Mrs. Mary J. Hitchens (daughter) Salisbury					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile atherosclerosis (c) Senile dementia									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senile dementia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 0-4-78 , 19 78 , to 3-25 , 19 79 , that (I) (we) last saw the deceased alive on 2-27 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b. SIGNATURE Roger C. Merrill				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger C. Merrill, M.D.				22e. ADDRESS Kay Ave., Salisbury, MD 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/28/79		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR APR 5 1979					
25b. REGISTRAR'S SIGNATURE John H. Brady									

12-01-00

100000

General Hospital

Salisbury



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-07906	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELTA L. HOLLOWAY				2a. DATE OF DEATH MONTH DAY YEAR MARCH 1 1979			2b. HOUR 9:30 A.M.	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 22 47		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS			7b. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY WOR				13c. CITY OR TOWN SHOWELL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS CAMPELLTOWN RD.			
14 FATHER'S NAME (FIRST MIDDLE LAST) CHARLES LEASURE				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) KATIE KRUMBINE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 216-14-2023		17 INFORMANT ADDRESS DORIS SMITH SELBYVILLE, DEL.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2030 Rinal Insufficiency 61 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Spasm Atherosclerotic Cardiovascular Disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/31 19 79, to 3/1 19 79, that (I) (we) last saw the deceased alive on 3/1 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Helen M. Baldado M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-4-79		23c. NAME OF CEMETERY OR CREMATORY SUNSET M.P.			23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN, WOR, MD			
24. FUNERAL DIRECTOR NAME ULRICH FUNERAL HOME						ADDRESS BERLIN, MD.		25a. DATE REC'D. BY REGISTRAR MAR 7 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy	

90-07600

Peninsula General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		79-07907-							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR	
ANNA		MARIE		HUGHES		MARCH		17 1979	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b HOUR	
Female		White		May 10, 1915		63		10 30 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Frederick, Md.		USA				Wicomico		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		Housewife		-----			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS	
Maryland		Wicomico		Salisbury				519 Tony Tank Lane	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
David Murray Stauffer		Bessie Kaufman							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No				Mr. Alton E. Hughes (husband) same as 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>5/9/79</u> , 19 <u>79</u> , to <u>3/17</u> , 19 <u>79</u> , that (I) (was) lost saw the deceased alive on <u>3/16</u> , 19 <u>79</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (do not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
<u>Joseph A. Grasso</u>		MM							
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
Joseph A. Grasso, M.D.		PGHMC, Salisbury, Md. 21801							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3/19/79		Parsons Cemetery		Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY FUNERAL HOME		Salisbury, Maryland		MAR 23 1979		<u>Jeffrey McCready</u>			

19-07907

Wentworth

Wentworth General Hospital

Salisbury

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

79-07908

1. DECEASED-NAME (Type or print) First Middle Last GERTRUDE E INSLEY			2a. DATE OF DEATH Month Day Year 3 01 1979			2b. HOUR 11:13			
3. SEX female		4. RACE caucas.		5. DATE OF BIRTH Sept. 3, 1898		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 126 Brohawn Ave.	
14. FATHER'S NAME First Middle Last Samuel LeCompte			15. MOTHER'S MAIDEN NAME First Middle Last Dora Olivia Christopher						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO.		17. INFORMANT Cambridge, Md. 21613 Mrs. Martha LeCompte, 313 Cemetery Av.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma breast metastasis 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/23 78 , to 3/1 79 , that (I) (we) last saw the deceased alive on 2/28 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Earl M. Beardsley				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/1/79	
22d. PHYSICIAN'S NAME (Type) EARL M. BEARDSLEY, M.D.				22e. ADDRESS U.S. 50-CIVIC AVE., SALISBURY, MD. 21801					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Mar. 4, 1979		23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		23d. LOCATION (City or Town) (County) (State) Salem, Dorchester, Md.			
24. FUNERAL DIRECTOR Curran Funeral Home, 308 High St. Cambridge				25a. RECORD BY REGISTRAR Mar 6 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady			

80070-03

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VRA 15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

79-07909

1. DECEASED-NAME (Type or print) First Middle Last JAMES R.ussell JONES			2a. DATE OF DEATH Month Day Year 5 28 79			2b. HOUR P 3:50 M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9-16 97		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.			
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RESTAURANT		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE VIENNA, MD.		13b. COUNTY DORCHESTER		13c. CITY OR TOWN VIENNA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RACE STREET	
14. FATHER'S NAME First Middle Last William H. Jones			15. MOTHER'S MAIDEN NAME First Middle Last Effie Mae Abbott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-07-2810		17. INFORMANT Address Mrs. Marie H. Jones, Vienna, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung with</u> DUE TO, OR AS A CONSEQUENCE OF <u>wide spread metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 79			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>79</u> , to <u>3/28</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>3/27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Earl M. Beardsley M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>3/28/79</u>				
22d. PHYSICIAN'S NAME (Type) EARL M. BEARDSLEY, M.D.					22e. ADDRESS RT. 50& CIVIC AVE, SALISBURY, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar. 31, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Vienna Dor. Md.			
24. FUNERAL DIRECTOR Thomas Funeral Home, Cambridge, Md.,					25a. REC'D BY REGISTRAR DATE APR 3 1979		25b. REGISTRAR'S SIGNATURE <u>Patricia M. Beardsley</u>		

JAMES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-07910	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia H JONES						2a. DATE OF DEATH MONTH DAY YEAR March 19, 1979			2b. HOUR 3:25 a.m.		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7-4-1912		6. AGE (IN YEARS LAST BIRTHDAY) 107 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md		9b. CITIZEN OF WHAT COUNTRY? U.S.A		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
12. CITY OR TOWN OF DEATH Salisbury		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		15. KIND OF BUSINESS OR INDUSTRY			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE 16b. COUNTY md Somerset						17. CITY OR TOWN Venton		18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19. FATHER'S NAME FIRST MIDDLE LAST Saul Hirsch		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Maddox		21. STREET ADDRESS Rt. 3 - Box 67, Prineas Ave							
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE OR UNKNOWN)		23. SOCIAL SECURITY NO. 218-20-3059		24. INFORMANT ADDRESS Rt. 3 - Box 67, Prineas Ave md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) gangrene of ② foot 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Advanced generalised arteriosclerosis (c) Diabetes Mellitus.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. Shrestha				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maheswari, Shrestha, M.D,				22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801							
23a. BURIAL (SPECIFY) CREMATION, REMOVAL		23b. DATE 3-24-79		23c. NAME OF CEMETERY OR CREMATORY Grace		23d. LOCATION CITY OR TOWN COUNTY STATE Venton Somerset md					
24. FUNERAL DIRECTOR NAME Addie James H 07 Somerset Ave				ADDRESS		25a. DATE REC'D BY REGISTRAR MAR 27 1979		25b. REGISTRAR'S SIGNATURE			

01070-97

Section 12, 2001

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79-07911
REG. NO.

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST Madelyne		MIDDLE Elizabeth		LAST Jones		2a DATE OF DEATH MONTH DAY YEAR March 17 1979		2b HOUR 12 53 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH - DAY - YEAR 2 - 24 - 73		6 AGE (IN YEARS LAST BIRTHDAY) 6 yrs.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 IF 1 YEAR OR OVER MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD							
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS Powellville, MD.	
14 FATHER'S NAME FIRST MIDDLE LAST Raymond V. Jones				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dlores Gladden									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 7516 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Congenital Biliary Atresia (c Biliary Cirrhosis) (c) } DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 hrs 6 yrs													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 3/9 1979, to 3/17 1979, that (II) (we) last saw the deceased alive on 3/16 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE Deirdre C. Koller MD				DEGREE MD				22c DATE SIGNED					
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS Medical Center Salisbury, Md									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3-20-79		23c NAME OF CEMETERY OR CREMATORY Riverside Cemetery				23d LOCATION CITY OR TOWN COUNTY STATE Libertytown, Wor., MD.					
24 FUNERAL DIRECTOR NAME Anne R. Burkay				24b ADDRESS 108 Williams St. Berlin, MD.		24c PHONE NO. 2181		24d DATE REC'D. BY REGISTRAR MAR 27 1979		24e REGISTRAR'S SIGNATURE Judy Mabury			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

[illegible]

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP.

11070-05

Historical

General Hospital

Colony

Medical

11070-05

11070-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07912

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Pearl Whitney Jones</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 3 1979</i>		2b. HOUR MIN. <i>11 45 PM</i>			
3. SEX <i>F</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 25 02</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>76</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Frederick, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD		
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Maryland</i>			13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>RT #2 Towson Ave.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Whitney</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Iida Smith</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <i>319-05-3496</i>		17. INFORMANT ADDRESS <i>Samuel D. Jones (Ch. 467C, Purnell St. Salisbury, Md.)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>2387</i> IMMEDIATE CAUSE (a) <i>Myeloproliferative disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one month</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Lymphoma.</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>2-7</i> 19 <i>79</i> to <i>3-3</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>3-3</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Roger Merrill</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>3-6-79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Roger Merrill MD</i>		22e. ADDRESS <i>307 Kay Ave., Salisbury, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-8-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. James A.M.C.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Neale-Creek area Md.</i>		
24. FUNERAL DIRECTOR <i>Jolly Memorial Chapel</i>		ADDRESS <i>PT #2, Jersey Rd. Salisbury, Md.</i>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Harry McCreedy</i>		

MAR 16 1979

19-07915

California Peninsula General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-07913 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANDREW LESTER Keefe			2a. DATE OF DEATH MONTH DAY YEAR MARCH 8, 1979			2b. HOUR 2:08 AM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9/14/1905		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Beaver Falls, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Accountant		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1119 S. Division St.	
14. FATHER'S NAME FIRST MIDDLE LAST David M. Keefe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Anna Stauffer			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II			
16b. SOCIAL SECURITY NO 214-10-9561A			17. INFORMANT Mrs. Gladys B. Keefe (wife) same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Congestive Failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>16 HOURS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>UMBILICAL HERNIA; CHRONIC OBSTRUCTIVE LUNG DISEASE</u>									
19a. DATE OF OPERATION <u>3-5-79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>18C PART-2</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>3-5</u> , 19 <u>79</u> , to <u>3-8</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>3-8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John M. Bloxom III M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3-8-1979</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN M. BLOXOM</u>				22e. ADDRESS <u>MEDICAL CENT., SALISBURY, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/10/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Salisbury, Wicomico, Maryland</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>HOLLOWAY FUNERAL HOME, Salisbury, Maryland</u>				25a. REC'D. BY REGISTRAR <u>MAR 17 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

19-07013

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-07914	
FOR Items 18b & 19a, & 19b 1- STATE Film#G531 5-25-79 as REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUTHER CULVIN KING						2a. DATE OF DEATH MONTH DAY YEAR MARCH 30, 1979			2b. HOUR 12 ⁰⁰ P.M.		
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR 2 10 1914		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY W.C. 13c. CITY OR TOWN QUANTICO						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT 1 Box B1-B			
14 FATHER'S NAME FIRST MIDDLE LAST Hamble						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Hutchins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 229-18-5479		17 INFORMANT ADDRESS Mr. Thomas King - Kilmarnock Va.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY 5609 IMMEDIATE CAUSE (a) Septis DUE TO, OR AS A CONSEQUENCE OF (b) peritonitis DUE TO, OR AS A CONSEQUENCE OF (c) peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 week 2 week	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 11 m 79 13 march		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction with bowel perforation				20a. AUTOPSY? NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8 am , 19 79 , to 10 pm , 19 79 , that (I) (we) last saw the deceased alive on 30 m , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Culvin King						DEGREE		22c. DATE SIGNED 30 m 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Forgash						22e. ADDRESS Medical Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-4-79		23c. NAME OF CEMETERY OR CREMATORY MT Olive Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wicomico Church Northumberland Va					
24 FUNERAL DIRECTOR NAME Anthony E. Ward						25a. DATE REC'D. BY REGISTRAR APR 1 1 1979		25b. REGISTRAR'S SIGNATURE P. J. ...			

MEDICAL CERTIFICATION

19-07314

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Wanted

Alphonse

Alphonse J. ...
Tennessee ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of or

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH79-07915
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John W. Larrimore			2a. DATE OF DEATH MONTH DAY YEAR 29 March 29 79		2b. HOUR 12 10 am					
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR July 21, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 615 Race street	
14. FATHER'S NAME FIRST MIDDLE LAST James Larrimore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-14-8064		17. INFORMANT ADDRESS John W. Larrimore, Jr.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sepsis</u> 3201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Pneumococcal Meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>24 hours</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Obstructive Lung Disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>29 March 19 79</u> to <u>29 March 19 79</u> , that (I) (we) last saw the deceased alive on <u>29 March 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE Joseph C. Fitzgerald M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 29 March 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph C. Fitzgerald M.D.				22e. ADDRESS Medical Center Salisbury Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 1, 1979		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor Md				
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.				25a. DATE RECEIVED BY REGISTRAR APR 11 1979		25b. LOCAL HEALTH OFFICER'S SIGNATURE <i>Notary Public</i>				



2008 COLLECTION

WV 1111

2008-01-12

Salisbury (Benjamin General Hospital)

the same subject

Salisbury (Benjamin General Hospital)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		79-07916						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
LILLIE M. LATHBURY								MARCH 15, 1979		1:00 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		WHITE		OCT. 11 1905		73		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
GUIMBY		U.S.A.				Wicomico				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
VA.		ACC.		GUIMBY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS			
WALTER SPENCE		Iva.		323-18-6659		KATHLEEN STEVENS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS					
NO		323-18-6659		KATHLEEN STEVENS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 4402 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Amputation left leg</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
3-1-79		Arteriosclerotic gangrene		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>79</u> , to <u>3-15</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>3-15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.		22b. SIGNATURE <u>E. Kent Carney</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-15-79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
E. Kent Carney		Salisbury, Md. 21801		BURIAL		MAR 18, 1979		GUIMBY		GUIMBY, Acc. Va.	
24. FUNERAL DIRECTOR (NAME)		24b. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Myrtle Jones Mapp J. W.				MAR 23 1979		Myrtle Jones Mapp J. W.					

MEDICAL CERTIFICATION

19-07016

Salisbury
Peninsula General Hospital
Wilmington

WALTON, GEORGE
WALTER, GEORGE
WALTON, KATHLEEN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR				79-07917	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL - - - Layfield			2a. DATE OF DEATH MONTH DAY YEAR MARCH 9, 1979		2b. HOUR 4:45 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 6, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Snow Hill, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) etired State Employee		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Asher R. Layfield			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Payne		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] Yes WW II		16b. SOCIAL SECURITY NO. 218-12-1557		17. INFORMANT ADDRESS Mrs. Betty J. Layfield (wife) same as 13	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hypoxia 410- DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest (c) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease - Atelectasis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) personally attended the deceased from March 19 77 to March 9, 19 79, that (I) was last saw the deceased alive on March 8, 19 79, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.					
22b. SIGNATURE Thomas C Hill Jr.		DEGREE M.D.		22c. DATE SIGNED 3/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C Hill Jr.		22e. ADDRESS Pine Bluff Road, Salisbury, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/11/79		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park Salisbury, Wicomico, Maryland	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 12 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy	

BP

10-01-01

Winnipeg

Peninsula General Hospital

St. John's

10-01-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA MARIE LEMON					2a. DATE OF DEATH MONTH DAY YEAR 3-14-79		2b. HOUR 2 ³⁰ P M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 29, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INscribe CHARTERED HOME STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ----	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 725 Jackson Sreet	
14. FATHER'S NAME FIRST MIDDLE LAST Warren Peter Linnett					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Adkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-20-2623		17. INFORMANT ADDRESS Mr. Orlando L. Lemon (husband) same as 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 492- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Recurrent Pneumothorax</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>2 mos.</u> <u>6 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 2-22-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumothorax				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from 2-22, 19 79, to 3-14, 19 79, that (I) (we) last saw the deceased alive on 3-14, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (did not) view the body after death.									
22b. SIGNATURE C. R. Layton				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-14-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. LAYTON				22e. ADDRESS PGH Salisbury					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/17/79		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park Salisbury, Wicomico, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR MAR 19 1979	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 19 1979					
				25b. REGISTRAR'S SIGNATURE R. H. Brady					

81070-01

10-07-18

Salisbury

General Hospital



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-07919

1- STATE REGISTRAR		FIRST ELMER		MIDDLE ALVIN		LAST LEUTNER		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3-7-79 19		7b. HOUR 10:15 A.M.	
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 5 05	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 3-7-79 19		2d. HOUR 11 M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		MD			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) Retired Farm Machine Empl		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3004 Ocean City Blvd.			
14. FATHER'S NAME FIRST MIDDLE LAST Albert E. Leutner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Kraft							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-28-2938		17. INFORMANT (wife) ADDRESS Elizabeth Leutner, same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Trauma 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:07x 3-7-79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto involved in collision.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) intersection, Rt. 50 & Tilghman Rd., Salisbury, Md.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Wicomico					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 3-8-79			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 3-9-79		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park, Salisbury, Wic., Md.				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Hill-Baker-Bounds, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR MAK L 1979		25b. REGISTRAR'S SIGNATURE 					

10-070-01

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BP

DHMM - 16 50M 1/76
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-07920	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN D. LUTZ						3-11-79		7:45 AM			
3 SEX FEMALE		4 RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 10 4 1910		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD					
10 CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY SOMERSET		13c. CITY OR TOWN WENONA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS MAIN ROAD			
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM DAUBERT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY EIFERT							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) - NO -				16b SOCIAL SECURITY NO. 216-16-7566		17 INFORMANT VIOLET SPAYDE		ADDRESS PRINCESS ANNE, MD. 21853			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous origin</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Rheumatoid arthritis</u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> 19 <u>79</u> to <u>3-10</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>3-6</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A.C. Mitchell</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 3/11/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. MITCHELL, M.D.								22e. ADDRESS SALISBURY MD 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/13/79		23c. NAME OF CEMETERY OR CREMATORY DORRANCE CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE DORRANCE LUZERN PA		
24. FUNERAL DIRECTOR <u>Leroy G. Webster</u>				ADDRESS RT. 3 Box 354 PRINCESS ANNE, MD. 21853		25a. DATE REC'D. BY REGISTRAR MAR 15 1979			25b. REGISTRAR'S SIGNATURE <u>Barbara McCreedy</u>		

10-03050

4
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

79-07921

1. DECEASED-NAME (Type or print) First Middle Last JULIA A. MARSHALL			2a. DATE OF DEATH Month Day Year 5 24 79		2b. HOUR 8:30A
3. SEX FEMALE	4. RACE WHITE		5. DATE OF BIRTH 6-28-89		6. AGE (In years lost birthday) 89 YRS.
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.
10. CITY OR TOWN OF DEATH SALISBURY, MD 21801		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Salisbury nursing home		12a. USUAL OCCUPATION (Kind of work done during normal life, even if retired.) HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) VIRGINIA		13b. COUNTY WORCESTER	13c. CITY OR TOWN POCOMOKE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER BOX 86 CEDAR HALL RD.
14. FATHER'S NAME First Middle Last William McCready			15. MOTHER'S MAIDEN NAME First Middle Last Ann Morgan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Address Etha Fisher - Pocomoke City, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> (c) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk yes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 79		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/8, 1979, to 3/24, 1979, that (I) (we) lost saw the deceased alive on 3/23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]				22c. DATE 3/24/79	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3-26-1979		Taylor Memorial	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	
[Signature]		Temperanceville Rd		DATE MAR 30 1979	
				25b. REGISTRAR'S SIGNATURE [Signature]	

15050-01

U.S. DEPARTMENT OF THE INTERIOR

150

WATER RESOURCES DIVISION

WASHINGTON, D.C.

1954

U.S. DEPARTMENT OF THE INTERIOR

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07922

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR			
DECEASED NAME (TYPE OR PRINT) EMMA G. McCabe			March 10, 1979			6:05 P.M.			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH 11 - 22-05		6 AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WORK WITH RETARDS -RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DELAWARE 13b. COUNTY SUSSEX		13c. CITY OR TOWN FRANKFORD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS GREEN ST.			
14 FATHER'S NAME WILLIAM A. LYNCH			15. MOTHER'S MAIDEN NAME SALLIE LYNCH			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 222-05-8497			17 INFORMANT ADDRESS DONALD OWENS, SALISBURY, MD.						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4292								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								(b) Atherosclerotic Cardiovascular Disease	
DUE TO, OR AS A CONSEQUENCE OF								(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Obstructive Pulmonary Disease, Diabetic, Renal insufficiency, Heart failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 3-8-1979, to 3-10-1979, that (I) (we) lost the deceased alive on 3-10-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James L. Clifford				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-10-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES L. CLIFFORD				22e. ADDRESS Medical Center Salisbury Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-14-79		23c. NAME OF CEMETERY OR CREMATORY CAREY'S CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FRANKFORD, SUSSEX, DEL.			
24. FUNERAL DIRECTOR NAME Watson, Gray & Melson				ADDRESS FRANKFORD, DEL.		DATE REC'D. BY REGISTRAR MAR 14 1979		25b. REGISTRAR'S SIGNATURE	

19-07022

Peninsula General Hospital

Salisbury

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-07923			
1- FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret ----- Michel				MAR 10 1979 8:25 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 3 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jersey City		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Verger (Church)		12b. KIND OF BUSINESS OR INDUSTRY Church	
13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Camelot Apts. Bldg. D-2 451	
14. FATHER'S NAME FIRST MIDDLE LAST Edmund ----- Kaim				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frita ----- Kunkler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -----				16b. SOCIAL SECURITY NO. 138-12-1116		17. INFORMANT ADDRESS Mr. Henry E. Michel Salisbury, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u>							
436- CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b) -----							
DUE TO, OR AS A CONSEQUENCE OF (c) -----							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) -----							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from Feb 22, 1978 to March 10, 1979, that (I) (we) lost saw the deceased alive on Mar. 9, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rodney A. Wenrich, M.D.				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH				22e. ADDRESS KAY AVE. SALISBURY Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/13/79		23c. NAME OF CEMETERY OR CREMATORY Linden Hill United Meth.		23d. LOCATION CITY OR TOWN RIDGEWOOD COUNTY STATE New York	
24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, P.A. Salisbury, MD				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 14 1979 [Signature]			

70-07823

Continental

Continental General Hospital

Salisbury



FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 79-07924	
1. DECEASED NAME (TYPE OR PRINT) MICHAEL R. MOORE						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3-30-79 8:20 P.M.				2b. HOUR							
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 14 55		6. AGE (IN YEARS) (LAST BIRTHDAY) 23 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 3-30-79		2d. HOUR 11							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico											
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.				13b. COUNTY Wicomico		13c. CITY OR TOWN Tyaskin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 16, Tyaskin Road							
14. FATHER'S NAME FIRST MIDDLE LAST Richard Moore						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Bramley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-66-4690		17. INFORMANT NAME ADDRESS John McCarty, Bivalve, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Trauma 8122 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 P.M. 3-30-79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Motorcycle accident, struck truck.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) intersection, Rt. 50 & Hobbs Rd., Salisbury, Wic., Md.				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Bivalve, Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 4-2-79									
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/2/79		23c. NAME OF CEMETERY OR CREMATORY Bivalve Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Bivalve, Md.							
24. FUNERAL DIRECTOR NAME ADDRESS Messick Funeral Home, Bivalve, Md.				25a. DATE REC'D. BY REGISTRAR APR 4 1979				25b. REGISTRAR'S SIGNATURE <i>John McCarty</i>									

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

9-07021



NAME: MICHAEL
DATE: 11 25 53
AGE: 25-29
SEX: M
RACE: W
HEIGHT: 5-10
WEIGHT: 150
BIRTH: 11-25-28
BIRTHPLACE: NEW YORK, N.Y.
EDUCATION: HIGH SCHOOL
OCCUPATION: UNEMPLOYED
MARRIAGE: SINGLE
MILITARY: NONE
RELIGION: ROMAN CATHOLIC
PARENTS: FATHER: JAMES MICHAEL, MOTHER: MARY MICHAEL
SIBLINGS: NONE
PREVIOUS RESIDENCES: 1111 1ST AVE, NEW YORK, N.Y.
CURRENT RESIDENCE: 1111 1ST AVE, NEW YORK, N.Y.
TELEPHONE: 1-212-1234567
SOCIAL SECURITY: 1-23-456789
FINGERPRINTS: TAKEN 11-25-53
PHOTOGRAPH: TAKEN 11-25-53
SIGNATURE: MICHAEL
DATE OF INTERVIEW: 11-25-53
INTERVIEWER: J. EDGAR HOOVER
AGENCY: NEW YORK OFFICE
REMARKS: NO OTHER INFORMATION
FILED: 11-25-53
BY: J. EDGAR HOOVER

EDUCATION: HIGH SCHOOL
OCCUPATION: UNEMPLOYED
MARRIAGE: SINGLE
MILITARY: NONE
RELIGION: ROMAN CATHOLIC
PARENTS: FATHER: JAMES MICHAEL, MOTHER: MARY MICHAEL
SIBLINGS: NONE
PREVIOUS RESIDENCES: 1111 1ST AVE, NEW YORK, N.Y.
CURRENT RESIDENCE: 1111 1ST AVE, NEW YORK, N.Y.
TELEPHONE: 1-212-1234567
SOCIAL SECURITY: 1-23-456789
FINGERPRINTS: TAKEN 11-25-53
PHOTOGRAPH: TAKEN 11-25-53
SIGNATURE: MICHAEL
DATE OF INTERVIEW: 11-25-53
INTERVIEWER: J. EDGAR HOOVER
AGENCY: NEW YORK OFFICE
REMARKS: NO OTHER INFORMATION
FILED: 11-25-53
BY: J. EDGAR HOOVER

EDUCATION: HIGH SCHOOL
OCCUPATION: UNEMPLOYED
MARRIAGE: SINGLE
MILITARY: NONE
RELIGION: ROMAN CATHOLIC
PARENTS: FATHER: JAMES MICHAEL, MOTHER: MARY MICHAEL
SIBLINGS: NONE
PREVIOUS RESIDENCES: 1111 1ST AVE, NEW YORK, N.Y.
CURRENT RESIDENCE: 1111 1ST AVE, NEW YORK, N.Y.
TELEPHONE: 1-212-1234567
SOCIAL SECURITY: 1-23-456789
FINGERPRINTS: TAKEN 11-25-53
PHOTOGRAPH: TAKEN 11-25-53
SIGNATURE: MICHAEL
DATE OF INTERVIEW: 11-25-53
INTERVIEWER: J. EDGAR HOOVER
AGENCY: NEW YORK OFFICE
REMARKS: NO OTHER INFORMATION
FILED: 11-25-53
BY: J. EDGAR HOOVER

EDUCATION: HIGH SCHOOL
OCCUPATION: UNEMPLOYED
MARRIAGE: SINGLE
MILITARY: NONE
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AGENCY: NEW YORK OFFICE
REMARKS: NO OTHER INFORMATION
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BY: J. EDGAR HOOVER

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER BY TELEPHONE. **PENDING** IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W/PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-07925	
1. DECEASED NAME (TYPE OR PRINT) EDNA WINIFRED MORRIS						2a. DATE KNOWN OF DEATH 3-14-79				2b. HOUR 1 A.M.	
3. SEX Female		4. RACE AA		5. DATE OF BIRTH 1 4 29		6. AGE (IN YEARS) 50		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico	
10. CITY OR TOWN OF DEATH Fruitland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 429 Ogle Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shuttlecock		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.						13b. COUNTY Wicomico		13c. CITY OR TOWN Fruitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME CHARLES						15. MOTHER'S MAIDEN NAME MAZIE JAMES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO						16b. SOCIAL SECURITY NO. 220-26-3086		17. INFORMANT ADDRESS MRS. MARIAN WRIGHT SALIS, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) Deputy M.D.				DATE SIGNED 3-15-79			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE 3-18-79		23c. NAME OF CEMETERY OR CREMATORY Greenwood Memorial				23d. LOCATION CITY OR TOWN Salisbury	
24. FUNERAL DIRECTOR NAME West-Fooks Funeral Home, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR MAR 19 1979				25b. REGISTRAR'S SIGNATURE [Signature]			

2007-05-05

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#5,6, Film G530 3/6/79 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07926

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Moses NICHOLS			2a. DATE OF DEATH MONTH DAY YEAR March 21, 1979			2b. HOUR p 1:20 M			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 11 16 1915		6. AGE (IN YEARS LAST BIRTHDAY) 65-63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SALISBURY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labourer		12b. KIND OF BUSINESS OR INDUSTRY Painter	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD. 13c. COUNTY Wicomico 13d. CITY OR TOWN Salisbury					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 632 W. Main St.		
14. FATHER'S NAME FIRST MIDDLE LAST Goldsmith Nichols					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Edgus				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1111-11-11		17. INFORMANT Dody Nichols			ADDRESS New Rochelle N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Carcinoma of prostate with generalized metastases and ascites. 185- DUE TO, OR AS A CONSEQUENCE OF Status post pathological fracture of left femur with surgery DUE TO, OR AS A CONSEQUENCE OF Cachexia secondary to #1.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/8/79 , 19____, to 3/21/79 , 19____, that (I) (we) last saw the deceased alive on 3/21/79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L.V. Maldve					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/21/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L.V. Maldve, M.D.					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-24-79		23c. NAME OF CEMETERY OR CREMATORY Groen Gores		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.			
24. FUNERAL DIRECTOR NAME Valley Memorial Chapel		ADDRESS 4143 E. 3rd St.		25a. DATE REG'D BY REGISTRAR MAR 27 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			

35
91
35
22
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

25070-25



MAR 2 1974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-07927
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTELLE Gertrude OAKES						2a. DATE OF DEATH MONTH DAY YEAR March 11, 1979		2b. HOUR 6:20 a.m.		
3. SEX female		4. RACE cauc.		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 76		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY wicomico		13c. CITY OR TOWN Delman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Hi Hiner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST lot 7 Gateway Village							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Carl Harrison - Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute renal failure, recurrent 5849 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH January, Feb. 1979	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 2/2 , 19 79 , to 3/11 , 19 79 , that (I) (we) lost saw the deceased alive on 3/11 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Joe Hwang			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/11/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. JOE HWANG			22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/13/79		23c. NAME OF CEMETERY OR CREMATORY Redmen's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Selbyville, Delaware			
24. FUNERAL DIRECTOR NAME Richard T. Watson			ADDRESS Selbyville, Del.			25a. DATE REC'D. BY REGISTRAR MAR 14 1979		25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy		

79-07927

Case No. 79-07927

Sept. 16, 1975

Room

Family

11.1.1.

10.1.1.1.

x

none

Don't know

Don't know

John J. Conway, Jr.

John J. Conway, Jr.

John J. Conway, Jr.

John J. Conway, Jr.

John J. Conway, Jr.

no

79-07927



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

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BP_____

DHMH-17
(VR A15 ME (5))
15M 7/77

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						79-07928 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		3-24-79		2b. HOUR 6:34P	
EDNA		M.				PARKER		2c. DATE PRONOUNCED DEAD		3-24-79		2d. HOUR "	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11 14 1886		6. AGE (IN YEARS) 92 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2e. DATE PRONOUNCED DEAD		2f. HOUR "	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico				MD	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Quantico		13d. INSIDE CITY LIMITS? YES NO		13e. STREET ADDRESS Rd					
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Cordrey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Cordrey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-46-4724		17. INFORMANT William Small		ADDRESS Salisbury, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4392 IMMEDIATE CAUSE (a) ASCVD Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES NO									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry, and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner													
ACTUAL SIGNATURE Earl L. Royer		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 3-26-79							
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.		ADDRESS 409 Camden Ave., Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-27-79		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Delmar Sussex Del.							
24. FUNERAL DIRECTOR NAME Marvel-Short Funeral Home, Delmar, De.		25a. DATE REC'D. BY REGISTRAR APR 5 1979		25b. REGISTRAR'S SIGNATURE H. McCreedy									

19-07928

PARKER

OWENS WHITE 11 1968 02

Salisbury Peninsula General Hospital

16. Island Hospital

19-07928

X X

109 Garden Ave., Salisbury, Md.

19-07928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-07929	
1. FOR STATE REGISTRAR <u>Richard L.</u>											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Richard Lee Parsons</u>						2a DATE OF DEATH MONTH DAY YEAR <u>March, 19, 1979</u>		2b HOUR <u>2A</u> M			
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>1 11 1924</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>55</u> YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD.					
10 CITY OR TOWN OF DEATH <u>Salisbury</u>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Exec Plumbing Firm</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>			
13a STATE <u>Maryland</u>		13b COUNTY <u>Wicomico</u>		13c CITY OR TOWN <u>Salisbury</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <u>Quantico Road</u>			
14 FATHER'S NAME FIRST MIDDLE LAST <u>Benjamin Frank Parsons</u>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Eva Marie Taylor</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>				16b SOCIAL SECURITY NO. <u>218-16-8167</u>		17 INFORMANT ADDRESS <u>Mrs. Doris Parsons Quantico Rd. Salisbury, Maryland</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction, Acute</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 yr</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>3/15</u> 19 <u>79</u> to <u>3/18</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <u>7/80</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. L. Raffetto</u>				22e ADDRESS <u>216 Ohio St. E. Salisbury, Md.</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>3-23-79</u>		23c NAME OF CEMETERY OR CREMATORY <u>Springhill Memory Gardens Salisbury Wicomico Md.</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Salisbury, Md.</u>		23e DATE REC'D. BY REGISTRAR <u>MAR 27 1979</u>			
24 FUNERAL DIRECTOR NAME <u>Holloway Funeral Home P.A.</u>				ADDRESS <u>Salisbury, Md.</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>					

79-07929

Albuquerque

Peninsula General Hospital

Albuquerque

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07930

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
WALTER		F.		Perdue	March 12	1979			2:35 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	January 24, 1898		81		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Snow Hill, Md.	USA			Wicomico MD					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Salisbury	Peninsula General Hospital		Accountant		Accounting				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b STATE	13c COUNTY	13d INSIDE CITY LIMITS?	13e STREET ADDRESS				
Maryland		Worcester	Snow Hill	YES <input type="checkbox"/> NO <input type="checkbox"/>	404 Circle Drive				
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
Harry F. Perdue		Minnie Holloway							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
No		214-30-8263		Mrs. Erma H. Perdue (wife) same as 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>									<u>Week</u>
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Chronic Lung Disease; Renal Insufficiency</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3/12/79</u> to <u>3/12/79</u> , that (I) (we) lost saw the deceased alive on <u>3/12/79</u> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
<u>John B. Green</u>						3/12/79			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
J.C. Green		Salisbury MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		3/15/79		Forest Grove Cemetery		Parsonsburg, Wicomico, Maryland			
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
HOLLOWAY FUNERAL HOME, Salisbury, Maryland				MAR 16 1979		<u>Erma H. Perdue</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

19-07880

Wichita

Salisbury Penitentiary General Hospital

MAR 16 1979

Item #18 Film G530 4/3/79 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07931

REG. NO.

1 - STATE
REGISTERAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Baby Boy Perry			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7 1979			2b. HOUR ⁰⁰ 9 P. M.	
3 SEX M		4 RACE NEGRO		5 DATE OF BIRTH MONTH DAY YEAR 1-7-79		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 21 -	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b KIND OF BUSINESS OR INDUSTRY							

13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS		
-----------	--	--	------------	--	--	------------------	--	--	--	--	--	--------------------	--	--

14 FATHER'S NAME FIRST MIDDLE LAST Keith Dashiield			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alexis Perry		
--	--	--	--	--	--

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Alexis Perry Rt 1 Box 254B Maryland	
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18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7468 IMMEDIATE CAUSE (a) Pending Autopsy DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1**

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE William C. Morgan		DEGREE		22c DATE SIGNED 1/8/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 1-8-79		23c NAME OF CEMETERY OR CREMATORY GREEN ARCES CEM		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury Wic. Md.	
---	--	---------------------------	--	---	--	---	--

24 FUNERAL DIRECTOR NAME Clinton F. Stewart		ADDRESS Salisbury		25a DATE RECD. BY REGISTRAR MAR 01 1979		25b REGISTRAR'S SIGNATURE Henry McBrady	
---	--	-----------------------------	--	---	--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-07031

100-07031

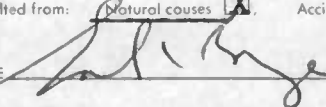
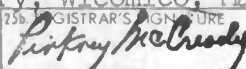
Benjamin's General Hospital

Salisbury

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

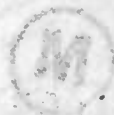
REC. NO. 79-07932

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE JANE POWELL			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3-2-79		2b. HOUR A M
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 11, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD March 3 19 79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 512 E. Church St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	
13a. STATE Maryland		13b. CITY OR TOWN Wicomico		13c. CITY OR TOWN Salisbury	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Alfred Townsend		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie W. Pruitt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT (brother) ADDRESS 337 Barclay St. Mr. Perless L. Townsend, Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 35 179	
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.		ADDRESS 409 Camden Ave., Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/7/79		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland		23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 7 1979	
25b. REGISTRAR'S SIGNATURE 					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10-01332



STATION

STATION

STATION

STATION

1

10-01332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-07933				
1. DECEASED NAME (TYPE OR PRINT) James REESE			2a. DATE OF DEATH MONTH DAY YEAR March 17, 1979			2b. HOUR 8:30 P				
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MARCH 7, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY XENT		13c. CITY OR TOWN CHESTER TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 218 FRONT STREET		
14. FATHER'S NAME FIRST MIDDLE LAST William REESE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE HELEN Goldsboro							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS MRS. REVA WARREN R.E. #3		CHESTER TOWN MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lachoxia 1481 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of Left piriform sinus DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. Shrestha					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/17/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha M.D.					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BUR. A 1		23b. DATE 3-22-1979		23c. NAME OF CEMETERY OR CREMATORY RICH NECK HALL		23d. LOCATION CITY OR TOWN COUNTY STATE CHESTER TOWN XENT MD				
24. FUNERAL DIRECTOR M. Shrestha					ADDRESS CHESTER TOWN MD		25a. DATE REC'D. BY REGISTRAR APR 4 1979		25b. REGISTRAR'S SIGNATURE M. Shrestha	

MEDICAL CERTIFICATION

50-01033



Handwritten notes on lined paper, including the word "HALL" and various numbers and symbols.

Handwritten notes on lined paper, including the word "HALL" and various numbers and symbols.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-07934
REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAVID JAY RICHSTONE										3. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 3-19-79		4. HOUR DAY 4:06 P M			
5. SEX Male		6. RACE White		7. DATE OF BIRTH MONTH DAY YEAR Dec. 21, 1915		8. AGE (IN YEARS LAST BIRTHDAY) YRS. 63		9. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		10. IF UNDER 24 HRS.		11. DATE PRONOUNCED DEAD MONTH DAY YEAR March 19 1979		12. HOUR H M			
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poughkeepsie, N. Y.				14. CITIZEN OF WHAT COUNTRY? USA				15. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				16. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.					
17. CITY OR TOWN OF DEATH Salisbury				18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printing Specialist				20. KIND OF BUSINESS OR INDUSTRY Government					
21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 134 Francis Drive							
22. FATHER'S NAME FIRST MIDDLE LAST Aaron Richstone				23. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tanya (unknown)				24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				25. SOCIAL SECURITY NO. 061-12-4212				26. INFORMANT Mrs. Hilda Richstone (wife) same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 3/20/79					
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/21/79		23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland							
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, ADDRESS Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 22 1979				25b. REGISTRAR'S SIGNATURE									

9-01884

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

100-1-1-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07935

REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Uber Ernest ROBINSON			2a DATE OF DEATH MONTH DAY YEAR MARCH 23 1979			2b HOUR 11:00 AM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 1 15 1909		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b KIND OF BUSINESS OR INDUSTRY None		
13a STATE Maryland			13b COUNTY Wicomico		13c CITY OR TOWN Willards		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Pine Street	
14 FATHER'S NAME FIRST MIDDLE LAST William Robinson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Figgs							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 6-22-42 to 6-45		17 INFORMANT ADDRESS Mrs. Lillian M. Robinson Willards, Md.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic sclerotic Heart Disease</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) <u>Thomas C. Hill Jr</u> attended the deceased from <u>Aug 67</u> to <u>March 23</u> 19 <u>79</u> , that (I) <u>lost</u> saw the deceased alive on <u>March 23</u> 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.										
22b SIGNATURE <u>Thomas C. Hill Jr</u>					DEGREE MD			22c DATE SIGNED 3/23/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. HILL JR					22e ADDRESS Pine Bluff Road, Salisbury, Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 3/25/79		23c NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.			
24 FUNERAL DIRECTOR NAME Holloway Funeral Home P.A.					ADDRESS Snow Hill Rd, Salisbury, Md		25a DATE REC'D. BY REGISTRAR MAR 27 1979		25b REGISTRAR'S SIGNATURE <u>Robert McBrady</u>	

BP

19-07032

Wisconsin

Kenilworth General Hospital

Kenilworth

RECEIVED
JUL 10 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-07936
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR	
DONALD		GRANT		TAYLOR				3-30-79		8:20				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR			
Male	White	8 8 53		25 YRS.						3-30-79		11		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
		U.S.A.		WIDOWED		DIVORCED		Wicomico							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury		DOA Peninsula General Hospital		bricklayer		building									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		Quantico Road							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Oscar Lee Taylor		Elizabeth Davis													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Father)		ADDRESS									
No		220-52-8967		Oscar Lee Taylor, Salisbury, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Multiple Trauma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		sudden							
		DUE TO, OR AS A CONSEQUENCE OF													
		DUE TO, OR AS A CONSEQUENCE OF													
		DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
8 (P.M.) 3-30-79		Motorcycle accident, struck truck.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN											
intersection, Rt. 50 & Hobbs Rd., Salisbury, Wic., Md.															
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion							
death resulted from:		Natural causes <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		Deputy		MEDICAL EXAMINER		DATE SIGNED		4-2-79					
EXAMINER'S NAME (TYPE OR PRINT)		Earl L. Royer, M.D.		ADDRESS		409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		4-2-1979		Wicomico Memorial P rk		Salisbury, Wicomico, Maryland									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Hill-Baker-Bounds, Salisbury, Md.				APR 6 1979		L. J. McCready									

9-07998

DATE: 9-30-79

TIME: 1-30-79

LOCATION: [illegible]

PERSONNEL: [illegible]

REMARKS: [illegible]

NAME: [illegible]

ADDRESS: [illegible]

PHONE: [illegible]

TELETYPE: [illegible]

WIRE: [illegible]

MAIL: [illegible]

TELEVISION: [illegible]

RADIO: [illegible]

NEWSPAPERS: [illegible]

OTHER: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-07937			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILDRED E. TOPPING				2a. DATE OF DEATH MONTH DAY YEAR 3-3-79			
3 SEX FEMALE		4 RACE W		5 DATE OF BIRTH 9-10-00 YEAR		6 AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN) OCEAN CITY		7b. CITIZEN OF WHAT COUNTRY? WOR		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.	
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SALISBURY NURSING HOME		12a. USUAL OCCUPATION (IF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD.				13b. CITY OR TOWN WOR.		13c. STREET ADDRESS RT. #1 BOX 272	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM POWELL				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BAKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-07-7214		17 INFORMANT ADDRESS NELSON TOPPIN OCEAN CITY, MD			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF (b) <u>Generalized atherosclerosis</u> DUE TO OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 4 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/10 19 76, to 3/3 19 79, that (I) (we) last saw the deceased alive on 3/2 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.							
22b. SIGNATURE <i>John P. Buckley</i>				DEGREE MD		22c. DATE SIGNED 3/3/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/5/79		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN WOR MD	
24 FUNERAL DIRECTOR NAME Anna A. Burkholder				24b. ADDRESS Berlin Md.		25a. DATE REC'D. BY REGISTRAR MAR 7 1979	
				25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>			

70250-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be reported to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-07938

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BERTHA ELIZABETH TRUITT			20. DATE OF DEATH MONTH MARCH DAY 18 YEAR 79			21. HOUR 1 P. M.				
3. SEX FEMALE		4. RACE white		5. DATE OF BIRTH MONTH 8 DAY 12 YEAR 90		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.				
10. CITY OR TOWN OF DEATH Snow Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harrison Nurse				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Sitter		12b. KIND OF BUSINESS OR INDUSTRY Nursing		
13a. STATE md.			13b. COUNTY Calvert		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Lemon Hill	
14. FATHER'S NAME E. DORA TRUITT			15. MOTHER'S MAIDEN NAME ANNIE E. FARLOW							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-18-5241		17. INFORMANT John B. Parsons ADDRESS Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Failure (b) Chronic Myocardial Infarction (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (If any)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 7/14 , 19 77 , to 3/18 , 19 79 , that (1) (was) last saw the deceased alive on 3/16 , 19 79 , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above, (1) (was) (did) (did not) view the body after death.										
22b. SIGNATURE Thomas W. Jones M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS W. JONES. M.D.			22e. ADDRESS 112 Pearl St. Snow Hill, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/21/1979		23c. NAME OF CEMETERY OR CREMATORY FARLOW'S Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Pittsville Wic. Md.		
24. FUNERAL DIRECTOR Hill-Baker-Bounds			ADDRESS Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR MAR 23 1979		25b. REGISTRAR'S SIGNATURE Kirby McCreedy		

MEDICAL CERTIFICATION

88070-05



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79-07939

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROLLIE HOWARD		2a. DATE OF DEATH MONTH DAY YEAR MARCH 29 1979		2b. HOUR 12 ²⁵ A. M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 15, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Govt. Employee Foreign Service		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Rollie H. White, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mineva Carr			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 579-14-1477		17. INFORMANT ADDRESS Mrs. Doris J. White (wife) same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung Cancer</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> , 19 <u>79</u> to <u>3/29</u> , 19 <u>79</u> , that (I) was last saw the deceased alive on <u>3/28</u> , 19 <u>79</u> , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death.					
22b. SIGNATURE <u>Joseph A. Grasso</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso		22e. ADDRESS PENINSULA GENERAL HOSPITAL SALISBURY Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/79		23c. NAME OF CEMETERY OR CREMATORY Green Hill Church Cemetery	
23d. LOCATION CITY OR TOWN Wicomico, Maryland		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland		25a. DATE REC'D. BY REGISTRAR APR 2 1979		25b. REGISTRAR'S SIGNATURE <u>Dorothy M. M...</u>	

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EXAMINER MUST BE NOTIFIED OF DEATH

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page number retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

19-07939

1900

Peninsula General Hospital

San Francisco

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m·1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

79-07940

1. DECEASED NAME (Type or print) RUSSELL		First M		Middle WHITE		Last		2a. DATE OF DEATH Month 3		Day 12		Year 1979		2b. HOUR 7:45^a	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9/21/1894		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 84		IF UNDER 24 HRS DAYS 84		IF UNDER 24 HRS HOURS 84		IF UNDER 24 HRS MIN 84	
7a. BIRTHPLACE (State or foreign country) Mo.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO								Md.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Oil Co.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Maxsela		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt 54							
14. FATHER'S NAME First Unknown		Middle 		Last 		15. MOTHER'S MAIDEN NAME First Unknown		Middle 		Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. 219-14-3200		17. INFORMANT Elizabeth Jones, Belair, Md.		Address 									
18. CAUSE OF DEATH (Enter only one cause per Part 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day yr.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Previous thrombi + myocardial infarct															
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) 											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f. LOCATION Street or R.F.D. No. City or Town County State 											
22a. I certify that (I) (this hospital) attended the deceased from 3/11 , 19 79 , to 3/12 , 19 79 , that (I) (we) last saw the deceased alive on 3/11 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Spill		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGN'D 3/12/79											
22e. DECEASED'S NAME (Type) Earl Beardsley, MD		22f. ADDRESS Salisbury, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/15/79		23c. NAME OF CEMETERY OR CREMATORY Maxsela Cem.		23d. LOCATION (City or Town) (County) (State) Maxsela, Md.									
24. FUNERAL DIRECTOR Emmerson, Bivins, Md.		25a. REC'D BY REGISTRAR MAR 20 1979		25b. REGISTRAR'S SIGNATURE Buttrick											



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07941

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Woodrow		W. Wilson		3-10-79		11:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		August 6, 1912		66		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Salisbury, Md.		USA				Wicomico		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		Journeyman tree pruner		-Power Co.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Salisbury		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		N. Schumaker Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Harry		L. Wilson		Yes		WW II		217-10-3706	
								Mrs. Maude E. Lloyd, Salisbury, Md.	
18. CAUSE OF DEATH		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		410- Massive Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				DUE TO, OR AS A CONSEQUENCE OF					
				DUE TO, OR AS A CONSEQUENCE OF					
				DUE TO, OR AS A CONSEQUENCE OF					
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from		3/6		1979		to		3/10	
saw the deceased alive on		3/10		1979		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Benito S. Chan		40		3/10/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
BENITO S. CHAN		547-D RIVERSIDE DR. SALISBURY MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		3/13/79		Pollitt Family Cemetery, Salisbury, Wicomico, Md.		CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS		MAR 14 1979		Holloway Funeral Home, Salisbury, Maryland					

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

10-07941

Wisconsin

Benjamin's General Hospital

Salisbury

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79-07942

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		March 5, 1979		10:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F		Negro		2 28 07		72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Columbia, Del.		USA				Wicomico MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital		Domestic		Housewife	
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13b. STREET ADDRESS			
				Rt 1 Box 39, Main St. Ext.			
14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
George W.		Lula Waller				29-07-7036	
17. INFORMANT (NAME AND ADDRESS)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
James Winder (add. same as above)		Cerebral thrombosis with left hemiplegia		4340			
		Arteriosclerosis and Vascular Insufficiency					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Cardiomegaly, Congestive heart failure, obesity, Mass Rt Breast							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 2/28, 19, to 3/5, 1979, that (I) (see) last saw the deceased alive on 3/5, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) did not view the body after death, so state.)							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
BAL AGARWAL		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/7/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BAL AGARWAL		PGH, Salisbury Md 21801		Burial		3-10-79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
John Wesley LM		Marble Springs-Wico, Md.		MAR 18 1979		Richard A. Brady	
24. FUNERAL DIRECTOR (NAME AND ADDRESS)		25. DATE REC'D. BY REGISTRAR		25f. REGISTRAR'S SIGNATURE			
Golden Memorial Chapel #42, Salisbury, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10-010-5

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

7

Wilmington

General Hospital

California

San Diego

California

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and report filed.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 79-07943

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) Katie A. Wooten		2a DATE OF DEATH MONTH DAY YEAR 3 18 79		2b HOUR 2 25 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 6, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD.		13b COUNTY Worcester		13c CITY OR TOWN Ocean City		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Bunting		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
16b SOCIAL SECURITY NO. 222-09-7528		17 INFORMANT ADDRESS Mr. Charles Townsend, Ocean City, Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>locking thoracic aortic aneurysm</u> 4411 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>3/16</u> , 19 <u>79</u> , to <u>3/18</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE W Ben Horner MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/18/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) W BEN HORNER		22e ADDRESS KAY AVE SALISBURY Md. 21801					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3-22-79		23c NAME OF CEMETERY OR CREMATORY Sunset Memorial		23d LOCATION CITY OR TOWN COUNTY STATE Berlin, Md. Worcester	
24 FUNERAL DIRECTOR NAME Anne A. Burbage		ADDRESS 108 Williams St. Berlin, Md. 21811		25a DATE REC'D. BY REGISTRAR MAR 27 1979		25b REGISTRAR'S SIGNATURE [Signature]	

9-01943

Alcoholic

Peninsula General Hospital

Alcoholic

Alcoholic

Alcoholic

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Alcoholic

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